October 10, 2023

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**EXECUTIVE SUMMARY**

**ALL COUNTY LETTER NO. 23-85**

The purpose of this All County Letter (ACL) is to issue the new *CalFresh Elderly Simplified Application* (CF 485). The CF 485 application for CalFresh is intended for use by older adults and people with disabilities who are eligible for the Elderly Simplified Application Project (ESAP).

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY
**DEPARTMENT OF SOCIAL SERVICES**
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

KIM JOHNSON
DIRECTOR

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October 10, 2023

ALL COUNTY LETTER NO. 23-85

TO: ALL COUNTY WELFARE DIRECTORS
ALL CALFRESH PROGRAM SPECIALISTS
ALL CALWORKS PROGRAM SPECIALISTS
ALL CONSORTIA REPRESENTATIVES
ALL QUALITY CONTROL PROGRAM COORDINATORS

SUBJECT: CALFRESH ELDERLY SIMPLIFIED APPLICATION (CF 485)

REFERENCE: AB 135, SECTION 77; WELFARE AND INSTITUTION CODE SECTION 18900.3; ALL COUNTY LETTER (ACL) 17-34; ACL 17-53; ACL 17-53E; ACL 20-145; ACL 21-02; ACL 21-101; AND ACL 22-15

The purpose of this All County Letter (ACL) is to issue the new *CalFresh Elderly Simplified Application* (CF 485). The CF 485 application for CalFresh is intended for use by older adults and people with disabilities who are eligible for the Elderly Simplified Application Project (ESAP).

## BACKGROUND

Assembly Bill (AB) 135 (Chapter 85, Section 77, Statutes of 2021) added Section 18900.3 to the Welfare and Institutions Code, which required the California Department of Social Services (CDSS) to develop a new user-centered simplified paper application for CalFresh, on or before July 1, 2023. The purpose of the new application is to increase CalFresh access and retention among older adults (age 60 or older) and people with disabilities who are eligible for the ESAP. CDSS must continue to maintain the simplified paper application for older adults and people with disabilities if the ESAP were to end.

ESAP is a demonstration project operated by the U.S. Department of Agriculture (USDA), Food and Nutrition Service (FNS) that seeks to increase Supplemental Nutrition Assistance Program participation among older adults by streamlining the application and certification process. CDSS has been authorized by the USDA FNS to

implement the ESAP through September 30, 2026 and has expanded it to include people with disabilities. CalFresh households are eligible for the ESAP if all household members are older adults (age 60 or older) and/or people with disabilities and have no earned income.

CDSS partnered with internal and external stakeholders to develop the new paper CF 485. The stakeholder engagement workgroup included divisions and branches within CDSS, state agencies that serve similar populations, county representatives, the County Welfare Directors Association of California, client advocates, the State Employee International Union, and the California Statewide Automated Welfare System (CalSAWS). The workgroup met several times between April 2022 and December 2022 to plan, develop, review, and provide feedback on the new user-centered simplified paper application.

## CALFRESH ELDERLY SIMPLIFIED APPLICATION

The goal of the CF 485 is to simplify and shorten the CalFresh application for older adults and people with disabilities. The application is intended for households in which every member applying for benefits:

1) Is at least 60 years or older and/or disabled,
2) Does not receive income from work, and
3) Purchases and prepares food together.

In comparison to the *Application for CalFresh Benefits* (CF 285), the overall flow of the application is different. The CalFresh eligibility questions are presented first, followed by *Important Information You Need to Know* and the *Rights & Responsibilities/Program Rules*. This user-centered design is intended to improve the application flow and continuity of information being presented to the applicant and/or recipient.

The CF 485 includes only those questions that are federally required and relevant to ESAP eligible households. This is intended to improve program access, decrease churn, and decrease administrative burden on the CWD.

## DIRECTIONS FOR USE OF CF 485

The CF 485 must be made available in the county office and upon request.

The CF 485 is a single signature form.

As a reminder, the only information required to submit a CalFresh application is name, address, and signature. However, applicants and/or recipients should be encouraged to submit a complete CF 485 to ensure a timely and accurate eligibility determination and benefit issuance.

While the CF 485 is designed specifically for use by ESAP eligible households, they can apply or recertify using any CalFresh application and be determined eligible for all other components of the ESAP (e.g., extended certification period with no semi-annual report required). Use of the CF 485 does not change or alter the requirements for ESAP eligible households as outlined in ACL 20-145 released on December 29, 2020.

## IMPLEMENTATION TIMELINE

Effective upon release of this letter, the CF 485 must be made available in the county office and upon request. The CWD must accept the CF 485 as a valid application for CalFresh.

The CF 485 is only issued as a paper form and is not automated in CalSAWS or available through the BenefitsCal online portal.

## NO SUBSTITUTES PERMITTED

To ensure statewide consistency and avoid unnecessary costs for the upkeep of multiple form versions, the CF 485 is deemed a "No Substitutes Permitted" form with the release of this letter.

The visual design of the form is intentional. As described in ACL 21-02, CWDs must not make any changes to the formatting. However, overprinting modifications may be permitted. Overprinting modifications for purposes other than those specified under MPP 23-400.211 must be pre-approved by the CDSS before use of the forms by CWDs. Refer to MPP 23-400.22 for approval procedures. Requests can be submitted to the CalFresh Policy and Employment Bureau at CalFreshpolicy@dss.ca.gov.

## COPIES AND TRANSLATIONS

Forms referenced in this letter are available on the CDSS Forms/Brochures webpage. When CDSS completes all translations of a form, they are posted on the Translated Forms and Publications webpage. When made available by CDSS, forms translated into an individual's preferred language must be provided to the individual pursuant to Manual of Policies and Procedures (MPP) Section 21-115.2. For questions on translated materials, please contact Language Services at (916) 651-8876. If translations are not available, recipients who have elected to receive materials in languages other than English should be sent the English version of the form or notice along with the GEN 1365-Notice of Language Services and a local contact number.

Per Government Code Section 7290, et seq., the CWD must ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services must be provided, free of charge, to the applicant/recipient. If CDSS does not provide translations of a form, it is the county's responsibility to read and interpret the form if an applicant or recipient requests it.

Additionally, the CWD must provide auxiliary aids and services to persons who are deaf or hearing impaired, or persons with impaired speech, vision, or manual skills, where applicable. More information regarding provisions for services to applicants and recipients who have limited English proficiency or who have disabilities can be found in MPP Section 21-115 and ACL 19-45.

If you have any questions or need additional guidance regarding the information in this letter, contact the CalFresh Policy and Employment Bureau at CalFreshPolicy@dss.ca.gov.

Sincerely,

***Original Document Signed By***

ALEXIS FERNÁNDEZ GARCIA
Deputy Director
Family Engagement and Empowerment Division

Attachment

# CALFRESH ELDERLY SIMPLIFIED APPLICATION

**This CalFresh application is used only if everyone applying is:**

- At least 60 or older and/or disabled.
- Not getting any income from work.
- Purchasing and preparing food together.

The application process begins when you give the county your name, address, and signature. Your application date is the day the county office gets your signed application. This will start the processing time to give you an answer on whether you can get benefits.
**Questions? See pages 6 & 7 for more information.**

## Tell us about your household

| | | |
|---|---|---|
| Applicant name (first, middle initial, last) | | |
| Physical address (street address, city, state, zip code) ☐ Home Address ☐ Institution ☐ Homeless | | |
| Mailing address (street address or PO box, city, state, zip code, if different from physical address) | | |
| Email address | Phone number where we can call you | Best time to call you |

You may choose someone at least 18 years old to help you with CalFresh benefits.

- This person is called an “Authorized Representative” (AR). The AR can help speak for you at the interview, help complete your forms, buy food for you, and/or report changes for you. ARs are not to be household members that purchase and prepare meals with the CalFresh applicant.
- You will have to repay any benefits you get by mistake because of information this person gives the county and any benefits you did not want them to spend will not be replaced.
- You will need to give the county proof of identity to act as an AR.

I want the person below to help me with my CalFresh case. ☐ Yes ☐ No

I want the person below to be allowed to get and spend CalFresh benefits for my household. ☐ Yes ☐ No

| | |
|---|---|
| Authorized Representative (first, middle initial, last) | Phone Number |
| Address (street address, city, state, zip code) | |

By signing below, I certify and agree that:

- I have read and understand the information on pages 6 & 7.
- I have read, understand, and agree to the Rights & Responsibilities/Program Rules on pages 8-10.
- I give my word, under penalty of perjury, that what I write in this application is correct and complete to the best of my knowledge and belief.

| | |
|---|---|
| Signature of Applicant/Authorized Representative | Date |

**You do not have to answer the following two questions, but they may help you get other services.**

1. Does anyone in your household have a disability? ☐ Yes ☐ No

   Tip: This includes anyone recovering from a disability or major illness.

   If **yes**, name of person(s): _____

2. Does anyone in your household need help due to a disability? ☐ Yes ☐ No

   Tip: This includes anyone needing help completing the eligibility process or anything benefits related.

   If **yes**, name of person(s): _____

## Expedited Service

Let's see if your household can get benefits within 3 days. Answer the questions below for everyone applying for CalFresh.

3. Is anyone a migrant/seasonal farmworker and has anyone's income stopped? ☐ Yes ☐ No
4. Is your household's gross income (before deductions) less than $150 this month? ☐ Yes ☐ No
5. Does your household have $100 or less in cash, including amounts in bank accounts? ☐ Yes ☐ No
6. Is your household's monthly rent/mortgage and utility costs more than your household's gross income and available cash this month? ☐ Yes ☐ No

**For the questions below, use additional space on page 5 or extra paper if needed.**

## Household Members

Tell us about everyone in the household.

| **Applicant (from page 1)** | | | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| Social Security Number | U.S. citizen? ☐ Yes ☐ No | Relationship to applicant **SELF** | Working? ☐ Yes ☐ No |

| Ethnicity (Optional): | Race (Optional): | Gender Identity (Optional): |
|---|---|---|
| ☐ Hispanic/Latino<br>☐ Non-Hispanic/Latino | ☐ American Indian/Alaska Native<br>☐ Asian<br>☐ Black/African American<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ White<br>☐ Other | ☐ Female<br>☐ Male<br>☐ Transgender Female<br>☐ Transgender Male<br>☐ Non-binary (neither male nor female)<br>☐ Another gender identity<br>☐ Decline to state |

## Household Members (Continued)

| Name (first, middle, last) | | | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| Social Security Number | U.S. citizen? ☐ Yes ☐ No | Relationship to applicant | Working? ☐ Yes ☐ No |

| Ethnicity (Optional): | Race (Optional): | Gender Identity (Optional): |
|---|---|---|
| ☐ Hispanic/Latino<br>☐ Non-Hispanic/Latino | ☐ American Indian/Alaska Native<br>☐ Asian<br>☐ Black/African American<br>☐ Native Hawaiian/Other Pacific Islander<br>☐ White<br>☐ Other | ☐ Female<br>☐ Male<br>☐ Transgender Female<br>☐ Transgender Male<br>☐ Non-binary (neither male nor female)<br>☐ Another gender identity<br>☐ Decline to state |

*<u>If more than 2 household members, please put their information on page 5 of this application</u>*

## Income

7. Does anyone in the household get income? ☐ Yes ☐ No

   If **yes**, tell us about all the income that everyone in your household gets. <u>Income may include</u> Social Security; Child Support; Alimony; Unemployment or Worker's Compensation; Disability benefits; money from friends or relatives; Pensions; Retirement benefits, SSI/SSP; Veteran's benefits.

| Person with income | Type of income | How much | How often | Date received |
|---|---|---|---|---|
| | | $ | | |
| | | $ | | |
| | | $ | | |
| | | $ | | |

## Resources

8. Does anyone in the household have any resources (cash, money in the bank, Certificate of Deposit, stocks, bonds, etc.)? ☐ Yes ☐ No

## Expenses

9. Does anyone in your household pay court-ordered child support? ☐ Yes ☐ No

| Person who pays | How much | How often |
|---|---|---|
| | $ | |

10. Who paid for dependent/child care? _____

    Amount paid for dependent/child care in $ _____

    Names of dependents/children: _____

    _____

11. Does anyone in your household pay more than $35 per month in out-of-pocket medical expenses? ☐ Yes ☐ No

If **yes**, tell us about any out-of-pocket medical expenses paid by anyone in your household. Expenses may include medications, doctor visits, hospital bills, transportation costs (including mileage), medical supplies, home health aides, service animal expenses, mental health expenses, and health insurance premiums. (Ask your county for a list of allowable expenses.)

| Person who pays | Type of medical expense | Amount paid monthly |
|---|---|---|
| | | $ |
| | | $ |
| | | $ |
| | | $ |

## Tell us about your household's shelter and utility expenses.

12. Does your household pay rent or mortgage? ☐ Yes ☐ No
If **yes**, what is the payment? $ _____ ☐ weekly ☐ monthly ☐ other

If you are homeless, do you have shelter costs? ☐ Yes ☐ No
If **yes**, what are your costs? $ _____ ☐ weekly ☐ monthly ☐ other

13. Does your household pay for any of the following costs? Check all that apply and specify if it is paid weekly, monthly, or other (If the cost is included in your rent or mortgage payment, do not list it here):

| | | | |
|---|---|---|---|
| ☐ Phone (including cell) | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Electric and/or Gas | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Water | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Trash | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Property tax: $_____ | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Home or Renter's insurance: $_____ | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Homeowner's Association (HOA) fees: $_____ | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Mobile home lot rent: $_____ | ☐ weekly | ☐ monthly | ☐ other |
| ☐ Other (please specify): $_____ | ☐ weekly | ☐ monthly | ☐ other |

_____

## Answer the questions below about everyone in the household.

14. Did anyone in your household win a substantial amount in a single bet or hand from lottery/gambling that is equal to, or greater than the maximum resource limit for elderly/disabled household members? ☐ Yes ☐ No

15. Has anyone been convicted of welfare fraud or misuse of benefits in any state? ☐ Yes ☐ No

16. Is anyone a fleeing felon or found to be in violation of their parole or probation? ☐ Yes ☐ No

17. Have you or any member of your household been convicted as an adult, after February 7, 2014, of aggravated sexual abuse, murder, sexual exploitation, and/or other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be similar to any of the offenses listed, and not in compliance with the terms of their sentence? ☐ Yes ☐ No

**Additional Writing Space (if needed):**

# Important Information You Need to Know

## Application Process

- Complete pages 1 to 5.
- Make sure you read pages 6 thru 10 and then **sign on page 1**.
- Make copies of any documents needed as proof (e.g., income, proof of identity for yourself, proof of out-of-pocket medical expenses, or power of attorney). You can submit any documents with your application.
- Submit your application:

  In-person, By Phone, By Mail, By Fax: To the county social services office where you live.

  Online: You can also apply for CalFresh or other programs online by going to http://www.benefitscal.com/.
- Complete an interview with the county to discuss your application. You have the option to complete your interview over the phone, in person at the county office, or another place arranged with the county.

**Have questions? Need help applying?** Call the CalFresh Benefits Helpline at 1-877-847-3663 or contact your county social services office. If you have limited English, ask for a free interpreter. If you need help because of a disability, dial 7-1-1 or talk to your county social services office.

## Noncitizens

- You can apply for and get CalFresh benefits for eligible people, even if your family includes others who are not eligible.
- Applying for or getting CalFresh benefits does not affect the immigration status for you or your family. CalFresh is **NOT** a "Public Charge." Immigration information is private and confidential.
- The immigration status of noncitizens who apply for benefits will be checked with the U.S. Citizenship and Immigration Services (USCIS). Federal law says the USCIS cannot use the information for anything else other than for cases of fraud.

## Opting Out

You do not have to give immigration information, Social Security numbers, or documents for any noncitizen family member(s) who are not applying for CalFresh benefits. The county will need to know their income and resource information to correctly determine your household's benefits. The county will not contact USCIS about the people who don't apply for CalFresh benefits.

## USDA Nondiscrimination Statement (Do Not Send Applications Here)

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local)

where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or write a letter addressed to USDA and provide in the letter all the information requested in the form to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. Submit your completed form or letter to USDA via the options provided below:

1. Mail: Food and Nutrition Service
U.S. Department of Agriculture
1320 Braddock Place, Room 334
Alexandria, VA 22314
*or*
Civil Rights Unit
P.O. Box 944243
M.S. 9-7-041
Sacramento, CA 94244-2430
2. Fax: (833) 256-1665 Fax: (202) 690-7442
3. Email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

**Do Not Send Applications Here**

## Privacy Act Statement

(i) The collection of this information, including the Social Security number (SSN) of each household member, is authorized under the Food Stamp Act of 1977, as amended, 7 U.S.C. 2011-2036. The information will be used to determine whether your household is eligible or continues to be eligible to participate in SNAP. We will verify this information through computer matching programs. This information will also be used to monitor compliance with program regulations and for program management.

(ii) This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing to avoid the law.

(iii) If a SNAP claim arises against your household, the information on this application, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

(iv) Providing the requested information, including the SSN of each household member, is voluntary. However, failure to provide an SSN will result in the denial of SNAP benefits to each individual failing to provide an SSN. Any SSNs provided will be used and disclosed in the same manner as SSNs of eligible household members.

Your county office may verify immigration status of household members applying for benefits. This is done by contacting the USCIS. Information the county gets from these agencies may affect your eligibility and level of benefits.

Your county office will check your answers using state and federal electronic databases. This includes the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a **consumer reporting agency**. The county may ask you to send proof if the information does not match.

## Rights & Responsibilities/Program Rules

**Call your county office to help understand your rights and responsibilities.**

**You may ask for a fair hearing if you disagree with a decision about benefits. To do so:**

- Call (800) 952-5253. For hearing rights or speech impaired who use TDD (800) 952-8349 *or*
- Go online at acms.dss.ca.gov *or*
- Fax the Hearing Request form to (833) 281-0905
- You may get free legal help at your local legal aid or welfare rights office. The back of your county notice lists your free local help or call the numbers listed above.

**You have the right to get a copy of this application.** Ask your county office for a copy.

**You have the right to a timely decision.** Unless there is a delay, an emergency, or an administrative problem beyond the county's control, expect a decision within 30 days of applying. For emergency benefits, you will get the county's decision within 3 days.

**You may get free aids & services to help you participate if you have a disability.** These are called "*reasonable accommodations*." Call your county office to ask for these, if needed.

**You have the right to privacy and confidentiality.** We will only share information about your case when it's connected to program administration, allowed by law/court order, or you give your permission. This is also required of all the agencies that work with us.

**Give proof of your household's expenses that may help you get more benefits.** Not giving proof to the county is the same as saying that you do not have that expense. You then will not be able to get more benefits.

**You need to report changes that could affect your benefits.** The county office will give you information about what, when, and how to report. If you don't report when required your CalFresh benefits may be lowered or stopped.

**You must provide a Social Security number (SSN) or proof that you have applied for an SSN for each person on this application.** Federal and State law requires it as a condition of eligibility. There are some exceptions. If you need more information about those exceptions, please ask your county office.

**You must tell the county right away if you get benefits from another state.** You must also report if anyone has been convicted of lying about where they live to get benefits from more than one state in the past 10 years.

**You must cooperate with the county and the state if your application is selected for a quality control review.** This includes giving proof of information and letting us get that proof if you can't.

**You need to give accurate information.** If the information is not accurate, benefits may be reduced and, you may be asked to repay benefits. If you are found to have intentionally given false or misleading information, you could be barred from getting benefits. You may also be charged with a crime.

**You must not:**

- sell your CalFresh benefits.
- use CalFresh to buy ineligible items (e.g., non-food, alcohol, or tobacco products).
- trade CalFresh for illegal drugs, firearms, ammunition, or explosives.
- let anyone use your EBT card unless they are buying food for your household.
- use or have someone else's EBT card unless you are buying food for their household.
- get food benefits in more than one state for the same month.

Anyone found guilty of any of the above misuse shall face penalties. This includes a ban from the CalFresh program for a specific period, a fine, and imprisonment. The specific period of the ban can be one year, two years, or permanently.

## Program Rules and Penalties

You are committing a crime if you give information that is false or untrue on purpose to try to get CalFresh benefits that you are not eligible to get. It is also a crime to on purpose help someone else get benefits that they are not eligible to get. You must pay back any benefits you get that you were not eligible to get.

| **Program Violations**<br>**For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:** | **Penalties**<br>**I may:** |
|---|---|
| • Hide information or make false statements<br>• Use Electronic Benefit Transfer (EBT) cards that belong to someone else or let someone else use my card<br>• Use CalFresh benefits to buy alcohol or tobacco<br>• Trade, buy, sell, steal, or give away CalFresh benefits or EBT cards, or attempt to trade, buy, sell, steal, or give away CalFresh benefits or EBT cards<br>• Try to get dual benefits, for example, apply in two or more different counties or states at the same time<br>• Submit false documents for children or adult household members who are not eligible or who do not exist<br>• Violate conditions of my probation or parole<br>• Flee after a felony conviction<br>• Purchase (buy) a product with CalFresh benefits that has a return deposit, intentionally (on purpose) throw away the contents and return the container for the deposit amount or attempt to return the container for the deposit amount<br>• Buy a product with CalFresh benefits and intentionally resell it for cash or anything other than eligible food | • Lose CalFresh benefits for 12 months for the first offense and be required to repay all CalFresh benefits overpaid to me<br>• Lose CalFresh benefits for 24 months for the second offense and be required to repay all CalFresh benefits overpaid to me<br>• Lose CalFresh benefits permanently for the third offense and be required to repay all CalFresh benefits overpaid to me<br>• Be fined up to $250,000 imprisoned up to 20 years or both |

| **Program Violations**<br>**For CalFresh: I understand I may have committed an intentional program violation if I do any of the following:** | **Penalties**<br>**I may:** |
|---|---|
| • Trade CalFresh benefits or attempt to trade CalFresh benefits for: cash, firearms, non-eligible goods, or controlled substances such as drugs | • Lose CalFresh benefits for 10 years for each offense<br>• Lose CalFresh benefits permanently |
| • Give false information about who I am and where I live, so I can get extra CalFresh benefits | • Lose CalFresh benefits for 24 months for the first offense |
| • Have been convicted of trading, selling, or attempting to trade CalFresh benefits worth more than $500, or trading or attempting to trade CalFresh benefits for firearms, ammunition, or explosives | • Lose CalFresh benefits permanently for the second offense |